POLICY BRIEF

Treatment Gaps in the Battle Against the Opioid Crisis:

An Examination of Opioid-Related Facility Visits

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Health care facilities are the frontline responders to the state's opioid crisis. In a recent report from the Rockefeller Institute of Government, opioid-related deaths in New York have skyrocketed 71 percent from 2010 to 2015.[1] While treating opioid addiction is an urgent public health priority, limited attention has been paid to issues of access and financing of opioid treatment. In this policy brief, we examine who pays for opioid treatment in New York State and the implications it has for access to healthcare.

Medicaid Pays for a Large Share of Opioid Treatment

Who pays for opioid treatment in New York? The answer varies by income.[2] Affluent people can get treatments for addiction through private insurance, elderly people may use Medicare, and low-income Americans may be eligible for Medicaid.

In New York State, most opioid-related facility visits[3] are paid for by the government through either Medicare or Medicaid (Figure 1). The remainder are provided through commercial insurers or private means. Specifically, 43.0 percent are paid for by Medicaid, followed by commercial insurers (33.1 percent), and Medicare (21.7 percent) in 2015.[4]

1 Jim Malatras, *By The Numbers: The Growing Drug Epidemic in New York* (Albany, Rockefeller Institute of Government, April 2017), http://www.rockinst.org/pdf/health_care/2017-04-20-By_numbers_brief_no8.pdf.

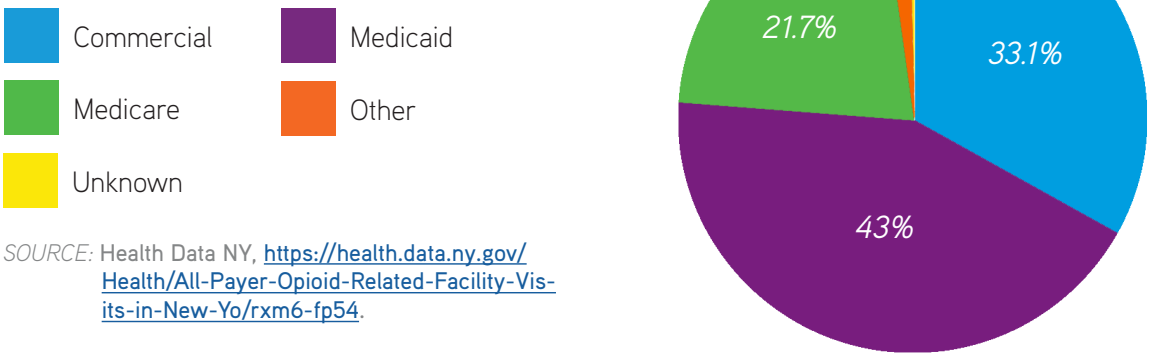
2 Jose A. Del Real, "Opioid Addiction Knows No Color, but Its Treatment Does," *New York Times*, January 12, 2018, https://www.nytimes.com/2018/01/12/nyregion/opioid-addiction-knows-no-color-but-its-treatment-does.html.

3 Opioid-related facility visits include emergency room, inpatient, ambulatory surgery, and outpatients. Inpatient visits are the largest share of opioid-related facility visits. Very few visits provide outpatient treatment.

4 Opioid-related facility visits by payer sources are calculated as the number of opioid-related visits by payer sources divided by the number of opioid-related visits paid by all payers (Medicare, Medicaid, commercial, other, and unknown) in New York State.

FIGURE 1.

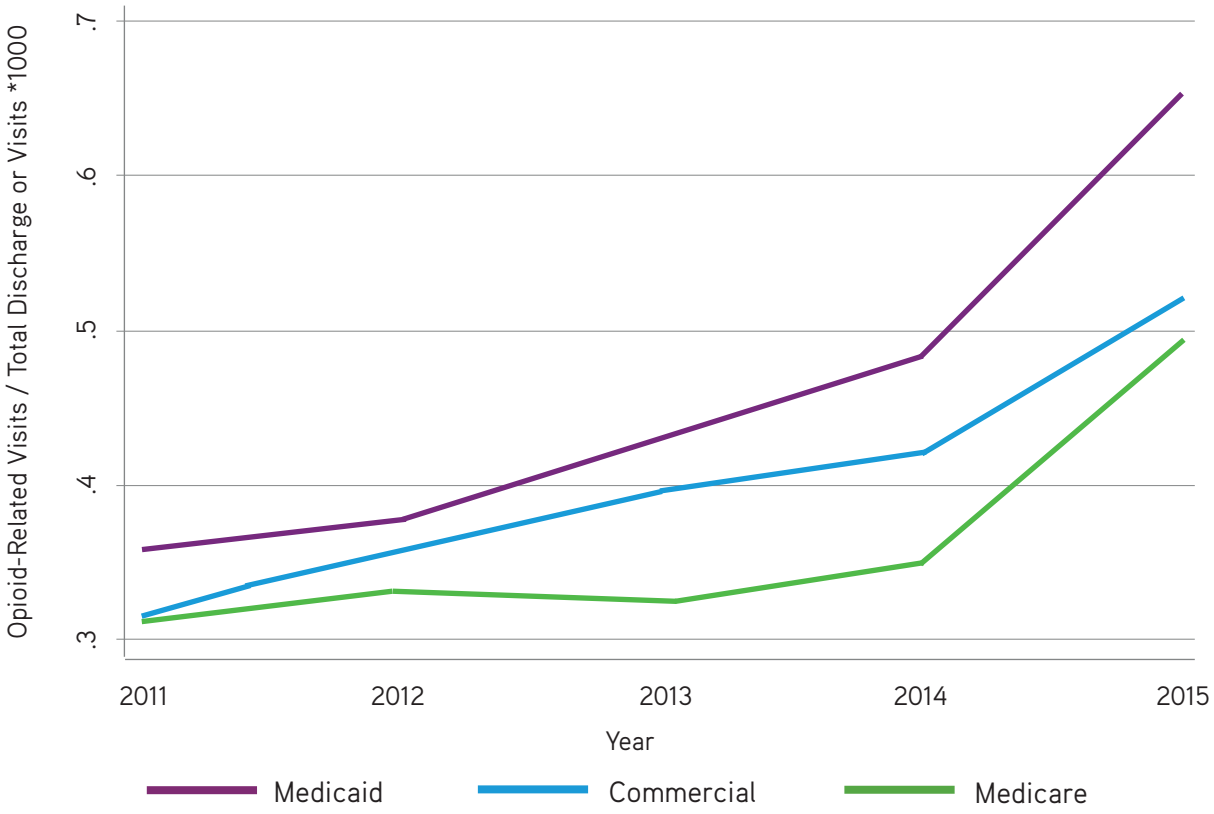
Opioid-Related Facility Visits in New York State by Payer Source



SOURCE: Health Data NY, https://health.data.ny.gov/Health/All-Payer-Opioid-Related-Facility-Visits-in-New-Yo/rxm6-fp54.

FIGURE 2.

Opioid-Related Facility Visits for Medicaid Are Rising Faster than Medicare or Private Insurance



Note: The y-axis indicates the average of opioids-related visits (per 1,000 total discharges or visits in all healthcare facilities including emergency room, inpatient, ambulatory surgery and outpatient) across counties in New York State. For example, "Commercial" represents the average among New York counties of opioids-related visits paid by commercial insurance companies (per 1,000 total discharges or visits in all facilities).

SOURCE: "All Payer Opioid-Related Facility Visits in New York State: Beginning 2010 (SPARCS)," Health Data NY, Updated January 2, 2018, https://health.data.ny.gov/Health/All-Payer-Opioid-Related-Facility-Visits-in-New-Yo/rxm6-fp54.

Opioid-Facility Visits Are Growing the Fastest for Individuals on Medicaid

Not only is Medicaid the single-largest funder of opioid facility treatment in New York, it is absorbing a growing share of the costs. As a proportion of all healthcare facility visits, opioid-related facility visits paid for by Medicaid doubled between 2011 and 2015 (Figure 2). Although facility visits paid by Medicare and commercial insurance have also increased over this period, their rates of increase have been much slower than the visits supported by Medicaid.[5] In 2015, Medicaid accounted for $8.7 billion of the total economic costs borne by all public and private insurers ($21.4 billion).[6]

Opioid-related facility visits paid for by Medicaid doubled between 2011 and 2015.

Even with Medicaid, Treatment Gaps Exist

Even though New Yorkers are visiting treatment facilities more often, and costs for treatment are growing, there may still be a substantial number of people who need but are not getting treatment, a problem called a "treatment gap."

New York State health data suggest that a substantial treatment gap may exist, even for Medicaid enrollees. It is widely documented that the face of the opioid epidemic has been mostly the poor, white population.[7] However, people in New York counties with relatively poor and white residents are less likely than people in other counties to present opioid-related problems when they visit healthcare facilities. That is true whether their visit is funded by Medicare, commercial insurance, or even Medicaid.

Figure 3 demonstrates this point. It shows the average proportions of all healthcare facility visits that are opioid related, by each of the major sources of funding (Medicaid, Medicare, and commercial). The averages are taken across counties in four categories:

- Group #1: Counties that have lower-than-average poverty rates (14.6 percent in 2015) and a lower-than-average proportion of whites (90 percent in 2015);
- Group #2: Counties with a higher-than-average poverty rate and lower-than-average proportion of whites;

5 Medicare-paid visits increased from 0.38 to 0.53 per 1,000 facility visits, while commercial insurance-paid visits grew from 0.34 to 0.57.

6 Maria Castellucci, "Economic burden of opioid epidemic hit $95 billion in 2016," *Modern Healthcare*, November 16, 2017, http://www.modernhealthcare.com/article/20171116/NEWS/171119908.

7 Nora Volkow, "Addressing the Opioid Crisis Means Confronting Socioeconomic Disparities," National Institute on Drug Abuse, October 25, 2017, https://www.drugabuse.gov/about-nida/noras-blog/2017/10/addressing-opioid-crisis-means-confronting-socioeconomic-disparities. The National Institute on Drug Abuse (NIDA) report attempts to understand which groups are more susceptible to drug use and addiction than others. This basic understanding is critical to reverse the opioid crisis and prevent future drug crisis. Factors associated with opioid drug abuse, such as economic disparities, housing instability, poor education quality, and lack of access to quality healthcare in disadvantaged regions, are discussed.

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- Group #3: Counties with lower poverty rates and over 90 percent white; and
- Group #4: Counties with higher poverty rates and over 90 percent white.

The average number of opioid-related facility visits (per 1,000 of all healthcare visits in 2015) are shown for each of these four groups of counties, and for each of the three sources of funding.

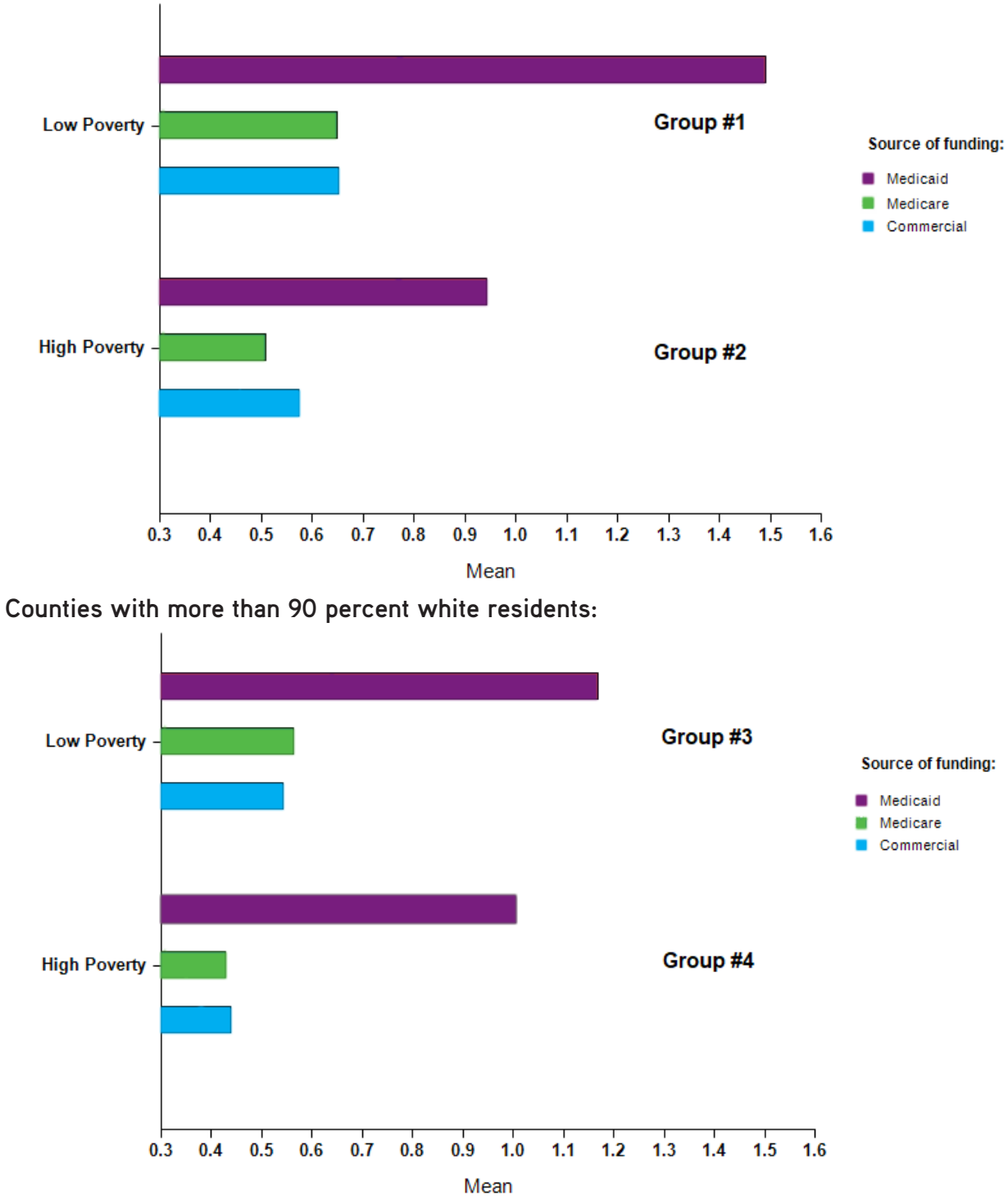
The highest rates of opioid-related visits to healthcare facilities are found in the relatively affluent, less-white counties (Group #1). The relatively poor and, especially, the poor and white counties (Group #4) show the lowest rates of opioid-related visits, regardless of funding source. Surprisingly, the pattern is even stronger in opioid-related facility visits paid for by Medicaid, which is designed to serve low-income individuals. Medicaid, for example, paid for 1.49 opioid-related facility visits (per 1,000 total healthcare facility visits) in affluent and less white counties. In comparatively poor and almost exclusively white counties, it paid for 0.94 opioid-related facility visits (per 1,000 total healthcare facility visits).

In other words, if opioid addiction is more common in comparatively poor, white communities, that pattern is definitely not evident in the numbers of opioid-related healthcare facility visits in New York State. Instead, we see higher rates of paid treatment for opioid-related problems in the more affluent and less exclusively white counties, including (indeed, especially) visits paid for by the Medicaid program.

FIGURE 3.

Average Opioid-Related Healthcare Facility Visits in Counties, By Relative Poverty and Percentage of White Residents (2015)

Each bar shows the average (mean) of the county-level numbers of opioid-related visits per 1,000 total discharges or visits in all health facilities.



SOURCE: Health Data NY, https://health.data.ny.gov/Health/All-Payer-Opioid-Related-Facility-Visits-in-New-Yo/rxm6-fp54.

Why Would a Treatment Gap Exist in Relatively Poor, White Counties?

Why might a treatment gap exist in poor, white counties? While Medicaid is a central source of healthcare funding for treatments of the opioid epidemic, many Medicaid enrollees with an opioid abuse disorder may still not be receiving treatment.[8]

One hypothesis is that healthcare providers are less accessible in certain communities. Groups #2 and #4, whose residents are more than 90 percent white, include many counties dominated by rural and small town communities. Their median population densities were 86 and 75 persons per square mile, respectively (2015 population data). Groups #1 and #3, both of which showed higher rates of facility visits, were much more urban or suburban, with population densities of 410 and 280, respectively. Perhaps individuals with opioid addictions in small towns and rural areas, even if they are eligible for Medicaid or Medicare, are simply less likely, and perhaps less able, to get to healthcare facilities.

Another possibility is that Medicaid enrollees may still struggle to get healthcare providers. Some physicians avoid treating Medicaid enrollees because Medicaid doesn't pay well. Medicaid reimbursement rates are lower than either Medicare or private payers, a problem not only for opioid treatment but other medical treatments and practices. Healthcare facilities with Medicaid dependency have fewer financial resources.[9] In cities and suburban communities, healthcare facilities may have options in dealing with Medicaid's financial burdens; in small, rural communities, they may not.

Medicaid also places administrative burdens on physicians, discouraging their participation. In general, the complexity of Medicaid rules and bureaucratic behavior reduce physician participation in Medicaid. Delays in Medicaid reimbursements negatively affect Medicaid participation among providers.[10] Simplifying the Medicaid administrative process and expediting reimbursement can be effective in increasing physicians' participation.[11] Lastly, treating Medicaid patients requires more time and

8 "Chapter 2: Medicaid and the Opioid Epidemic," in *Report to Congress on Medicaid and CHIP* (Washington, DC: Medicaid and CHIP Payment and Access Commission (MACPAC), June 2017), https://www.macpac.gov/wp-content/uploads/2017/06/Medicaid-and-the-Opioid-Epidemic.pdf.

9 Young Joo Park and Erika G. Martin, "Geographic Disparities in Access to Nursing Home Services: Assessing Fiscal Stress and Quality of Care," Early View Article, *HSR: Health Services Research*, November 12, 2017, http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12801/abstract; and Vincent Mor et al., "Driven to Tiers: Socioeconomic and Racial Disparities in the Quality of Nursing Home Care," *Milbank Quarterly* 82, 2 (2004): 227-56, http://onlinelibrary.wiley.com/doi/10.1111/j.0887-378X.2004.00309.x/full.

10 Peter J. Cunningham and Ann S. O'Malley, "Do Reimbursement Delays Discourage Medicaid Participation By Physicians?," *Health Affairs* 28, 1 (2009): w17-w28, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.28.1.w17.

11 Sharon K. Long, "Physicians May Need More Than Higher Reimbursements To Expand Medicaid Participation: Findings From Washington State," *Health Affairs* 32, 9 (2013): 1560-67, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2012.1010.

attention than non-Medicaid patients due to the complexity of patients' needs.[12] Again, healthcare facilities in larger communities may have the resources to deal with these issues, while those in smaller communities might not.

The Rockefeller Institute of Government is currently doing field research on the opioid crisis in a rural county in New York, and our discussions with providers and administrators there echo many of the same themes. Medicaid participation imposes burdens on physicians. New York State law, which requires physicians to consult a database of a patient's opioid prescriptions before writing a prescription of their own, and to enter their opioids prescriptions, is more than some physicians are willing to take on.

Since Medicaid plays a critical role in treating opioid addiction, it is important to understand why it may not be covering the costs of opioid-related facility visits in New York, particularly for low-income people. Whether the lower rate of facility visits is due to the accessibility of facilities, to healthcare professionals and institutions rejecting Medicaid patients, or to other factors, a serious effort to combat opioids addiction must seek to reduce differences in access, despite New York's comparatively generous Medicaid program.

12 Ellen Bouchery, Rebecca Morris, and Jasmine Little, *Examining Substance Abuse Disorder Treatment Demand and Provider Capacity in a Changing Health Care System: Initial Finding Report* (Washington, DC: Office of Disability, Aging and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, September 30, 2015), https://aspe.hhs.gov/system/files/pdf/203761/ExamSUD.pdf; Long, "Physicians May Need More Than Higher Reimbursements."

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